Policy Brief

Mental Health and the Criminal Justice System

Why Does This Matter?

Significant numbers of inmates have mental illness and/or substance use disorders, with approximately 60-80% of inmates with substance use problems[1,2,3] and 10-20% with serious mental illness[4]. There is also substantial overlap between the two populations. This striking reality calls for increased attention to the intersection between mental health and the criminal justice system (a) prior to, (b) during, and (c) after incarceration with an aim to end the criminalization of mental health challenges.

Policy Implications

Policy makers could, prior to incarceration:

- Support interventions that not only target mental illness, but also the broad set of individual and environmental risk factors—such as addiction, issues with medication adherence, stress, and trauma, as well as housing, education, and employment needs—that put people with serious mental illness at greater likelihood of running afoul of the criminal justice system. Put simply, people with mental health issues need more holistic interventions and they need them earlier.
- Address the lack of access to community mental health and co-occurring disorder services.
- Support diversion programs into community-based alternatives to incarceration. Example programs include Crisis Intervention Training for law enforcement officers, mental health and drug courts, and collaborative community courts which have relationships with local neighborhoods.

Policy makers and correctional institutions could, during incarceration:

- Improve jail and prison conditions, including: reducing overcrowding; providing diverse programming, including options for education, spiritual engagement, art, and exercise; supporting regular and non-cost-prohibitive contact with family and other community supports; and safely minimizing the use of punitive or protective segregation and super-maximum control units.
- Improve identification of and response to mental health and substance use disorders in correctional settings through early and effective screening; training for the identification and support of mental health problems by correctional officers; joint treatment planning with community providers and relevant support systems to allow continuity of care; recovery-oriented psychopharmacology, psychotherapy, dual diagnosis, and psychiatric rehabilitation services; improved options for medications including medication-assisted treatment (MAT) for substance use disorders; rigorous and comprehensive suicide prevention programs; and comprehensive and coordinated health care services.

Our western European allies have dramatically lower crime and extraordinarily different criminal justice systems (because)…they consider public health matters many of the things that we explicitly or implicitly criminalize, such as mental illness and substance abuse. – Criminologist William R. Kell

Policy Implications (continued)

Policy makers, correctional institutions, and nonprofit and community organizations could, after incarceration:

- Undertake transitional treatment planning with established appointments and an adequate supply of any necessary medications to help bridge individuals until their appointments; provide assistance with securing relevant benefits, including financial assistance and health insurance, to be activated upon release; institute forensically-oriented case management services; make available affordable housing, including supportive housing programs which do not discriminate against individuals with forensic histories; provide specialty parole/probation services; and offer Forensic Assertive Community Treatment (FACT) Teams.
- Provide organizational support for these changes by: creating oversight bodies to ensure that correctional services meet quality standards for mental health and dual diagnosis services to inmates; encouraging and publicizing cost studies for these interventions; educating legislators, policy makers, and the public concerning the effective nature of these recommendations; creating alliances with governmental, professional, advocacy, and correctional organizations to support these recommendations; developing task forces with relevant stakeholders, including incarcerated and previously incarcerated individuals themselves; and advocating to end mass incarceration of Americans, particularly persons from ethnic and socio-economic minorities.

What the Research Says

- Researchers have identified a number of risk factors (e.g., poverty, child abuse, community violence) for criminal behavior[5,6,7] that suggest crime prevention efforts should include community-based approaches.

- Access to quality mental health services (MHS) is not available in many communities, even prior to entering jail or prison.[8,9] Lack of access means that individuals may become incarcerated as a direct result of symptomatic behavior.[10]

- The increased use of incarceration as the primary response to drug use has led to a dramatic increase in the number of individuals with substance use disorders behind bars.[11]

- Ineffective screening procedures in correctional facilities leave many individuals with mental health challenges unidentified and in need.[12]

- Conditions in jails and prisons and disconnection from family and community supports exacerbate mental illness.[13] Confinement, overcrowding, exploitation, limited autonomy, and idleness all increase the likelihood of decompensation.[14] Further, inmates with mental illness are frequently housed in protective or punitive segregation, and this isolation leads to further deterioration of their conditions.[15,16]

- There is little continuity of care between correctional and community mental health and addiction services.[17,18] There is no communication with community providers at the time of incarceration, and individuals whose condition may have deteriorated in prison are often released directly to the community with no transition planning. Such lack of planning places individuals at high risk for homelessness, psychiatric hospitalization, and re-incarceration.[19]

Facts at a Glance

- The United States is the world's leader in mass incarceration.[20]

- More than 2.2 million people are in prison or jail, which represents a 500% increase over the last 40 years.[20]

- About 15% of men and almost one-third of women in jail settings have a serious mental illness.[21]

- The rates of serious mental illness in state prison populations are at least 2 to 4 times higher than community populations.[22]

- More than 3 times as many persons with severe mental are serving time in jails and prisons than receiving treatment in hospitals.[23]

- Approximately 83% of people with mental illness in jails do not receive care.[24]

- Over 70% of women in jails with serious mental illness also have a co-occurring substance use disorder.[25]

- 1 in 5 incarcerated individuals are locked up for a drug offense.[26]

- People with serious mental health concerns are more likely to be violently victimized and to be housed in segregation while in prison. They are also more likely to stay in prison for longer periods of time.[14]

- About 25% of inmates with mental illness in state prisons have been previously incarcerated 3 or more times.[14]

[1] Beck A. J., Harrison P. M., & Karberg J. C. (2002). *Prison and jail inmates at midyear 2001.* Bureau of Justice Statistics Bulletin (NCJ 191702). Retrieved from http://bjs.ojp.usdoj.gov

[2] Conklin, T. J., Lincoln, T., & Tuthill, R. W. (2000). Self-reported health and prior health behaviors of newly admitted correctional inmates. *American Journal of Public Health, 90,* 1939-1941.

[3] Columbia University, Center on Addiction & Substance Abuse. (2010). *Behind bars II: Substance abuse and America's prison population.* New York, NY: Author.

[4] James, D. J., & Glaze, L. E. (2006). *Mental health problems of prison and jail inmates* (NCJ 213600). Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.

[5] Institute of Medicine and National Research Council. (2001). *Juvenile crime, Juvenile justice.* Washington, DC: The National Academies Press.

[6] Herrenkohl, T.L., Hawkins, J.D., Chung, I., Hill, K.G., and Battin-Pearson, S. 2001. School and community risk factors and interventions. In Child Delinquents: Development, Intervention, and Service Needs, edited by R. Loeber and D.P. Farrington. Thousand Oaks, CA: Sage Publications, pp. 211–246.

[7] McCord, J., Widom, C.S., and Crowell, N.A., eds. 2001. Juvenile Crime, Juvenile Justice. Panel on Juvenile Crime: Prevention, Treatment, and Control. Washington, DC: National Academy Press.

[8] Mental Health America. (2017). *Prevention and early intervention B4Stage4: The state of mental health care in America 2016.* Retrieved from http://www.mentalhealthamerica.net

[9] Murphey, D., Vaughn, B., & Barry, M. (2013). *Access to mental health care* (Publication # 2013-2). Retrieved from http://www.childtrends.org

[10] Junginger, J., Claypoole, K., Laygo, R., & Crisanti, A. (2006). Effects of serious mental illness and substance abuse on criminal offenses. *Psychiatric Services, 57,* 887-882.

[11] The Sentencing Project. (n.d.). *Criminal justice facts.* http://www.sentencingproject.org/criminal-justice-facts/

[12] Gonzalez, J. M. R., & Connell, N. M. (2014). Mental health of prisoners: Identifying barriers to mental health treatment and medication continuity. *American Journal of Public Health, 104,* 2328-2333.

[13] Guy, A. (2016). *Locked up and locked down: Segregation of inmates with mental illness.* Retrieved from http://avidprisonproject.org/; Haney, C. (2001). *The psychological impact of incarceration: Implications for post-prison adjustment.* Retrieved from http://www.aspe.hhs.gov

[14] Kim, K., Becker-Cohen, M., & Serakos, M. (2015). The processing and treatment of mentally ill persons in the criminal justice system: A scan of practice and background analysis. Retrieved from http://www.urban.org

[15] Kaba, F., Lewis, A., Glowa-Kollisch, S., Hadler, J., Lee, D., Alper, H., . . . Venters, H. (2014). Solitary confinement and risk of self-harm among jail inmates. *American Journal of Public Health, 104,* 442-447.

[16] Metzner, J. L., & Fellner, J. (2010). Solitary confinement and mental illness in U.S. prisons: A challenge for medical ethics. *Journal of the American Academy of Psychiatry and the Law, 38,* 104–108.

[17] Binswanger, I. A., Nowels, C., Corsi, K. F., Long, J., Booth, R. E., Kutner, J., & Steiner, J. F. (2011). From the prison door right to the sidewalk, everything went downhill: A qualitative study of the health experiences of recently released inmates. *International Journal of Law and Psychiatry, 34,* 249-255.

[18] Baillargeon J, Hoge SK, Penn JV. Addressing the challenge of community reentry among released inmates with serious mental illness. Am J Community Psychol. 2010;46(3–4):361–75.

[19] Osher, F., Steadman, H. J., & Barr, H. (2002). *A best practice approach to reentry from jails for inmates with co-occurring disorders: The APIC model.* Delmar, NY: The National Gains Center.

[20] The Sentencing Project. (n.d.). *Criminal justice facts.* Retrieved from http://www.sentencingproject.org

[21] Steadman, H. J., Osher, F., Clark Robbins, P., Case, B., & Samuels, S. (2009). Prevalence of serious mental illness among jail inmates. *Psychiatric Services, 60,* 761-765.

[22] Prins, S. J. (2014). The prevalence of mental illnesses in U.S. state prisons: A systematic review. *Psychiatric Services, 65,* 862-872.

[23] Torrey, E. F. (2010). More mentally ill persons are in jails and prisons than hospitals: A survey of the states. Retrieved from http://www.treatmentadvocacycenter.org

[24] National Alliance of Mental Illness. (n.d.). *Jailing people with mental illness.* Retrieved from http://www.nami.org

[25] Abram, K. M., Teplin, L. A., McLelland, G. M. (2003). Comorbidity or severe psychiatric disorders and substance use disorders among women in jail. *American Journal of Psychiatry, 160,* 1007-1010.

[26] Wagner, P., & Rabuy, B. (2017). Mass incarceration: The whole pie (2017). Retrieved from http://prisonpolicy.org